WASHINGTON

# Medical Commission

Licensing. Accountability. Leadership.

## Policy Committee Meeting

## June 27, 2024

# Policy Committee Meeting

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at the Policy Committee meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

**Virtual via Teams Webinar: Registration link can be found below.**
**Physical location: 111 Israel Rd SE, TC2 Room 153, Tumwater, WA 98501**

## Thursday, June 27, 2024

### Open Session

| 4:00 pm | Agenda | |
|---|---|---|
| To attend virtually, please **register** here: WMC Policy Committee | | |
| The purpose of this meeting is to allow anyone to comment on and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. The WMC encourages open discussion on the items on this agenda. | | |
| **Organizer:** Pam Kohlmeier, MD, JD, Policy Manager | | |
| **1** | **Procedure: Processing Complaints Against Medical Students, Residents, and Fellows**<br>*Review and discussion of current document and proposed revisions.*<br>Draft with Track Changes on pages 3-8<br>Draft accepting above Track Changes (aka "clean") on pages 9-12 | |
| **2** | **Proposed Policy: Commissioner and Pro Tem Recusal Policy to Address Conflicts of Interest**<br>*Discussion of proposed policy.* | Pages 13-19 |
| **3** | **Proposed Policy: Artificial/Assistive Intelligence (AI)**<br>*Discussion of proposed policy.* | Pages 20-26 |
| **4** | **Policy: Telemedicine, POL2021-02**<br>*Review and discussion of current document and recommendation to rescind.*<br>Memo on page 27<br>Current policy on pages 28-34 | |
| **5** | **Proposed Policy: Clinical Experience Assessment**<br>*Discussion of proposed policy and assessment form.* | Pages 35-40 |
| **Public Comment**<br>*The public will have an opportunity to provide comments on this agenda. If you would like to comment, please use the Raise Hand function, or add your comments to the chat. Please identify yourself and who you represent, if applicable. If you would prefer to submit written comments, please email medical.policy@wmc.wa.gov by 5 pm on June 26, 2024.* | | |



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# Procedure

WASHINGTON Medical Commission
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# Processing Complaints Against ~~Medical~~ Students~~, Residents,~~ and Resident Physicians~~Fellows~~

## Introduction

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (Commission~~WMC~~) occasionally receives complaints[1] against students ~~medical students~~and resident physicians (~~,~~residents) while they are in training. ~~and fellows.~~ Because of the highly ~~-~~supervised environment in which they are ~~they~~ practicing~~e~~ medicine, the Commission provides~~WMC creates this procedure for~~ practitioners (students, residents, and their supervising attending physicians and program directors) and the general public the following procedure on how complaints against residents and physician assistant (PA), anesthesiology assistant (AA), and allopathic medical (MD) students are handled.

## Physician Assistant, Anesthesiology Assistant, and Medical Student Complaints

A. *Referring Complaints to Program Directors and Deans.* PA, AA, and MD students are generally in the early stages of learning and practicing medicine, have little control over their practice conditions, and are being monitored in a highly structured, supervised environment. While the Commission has authority to handle complaints against PA, AA, and MD students, the Commission recognizes that training program directors and deans are generally better equipped to address standard of care concerns than the Commission; thus, these students should practice medicine within their training programs without fearing the Commission.

1. *PA students.* Under authority of Revised Code of Washington (RCW) 18.71A.020(2(a)(i), PA students are legally permitted to practice medicine during training without a license. If a PA student has a complaint filed against them in that capacity, the Commission is likely to share the complaint with their training program director or dean, and the Commission is unlikely to open an investigation. If, however, the Commission receives a complaint against a PA student involving the practice of medicine *outside* of their training program, or involving a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct, the Commission may choose to investigate the complaint. If an investigation leads to a finding of unprofessional conduct,[2] and the Commission decides that discipline is necessary to protect the public, the Commission may impose discipline under authority of chapters 18.71A.120 RCW and 18.130 RCW.

[1] For the purpose of this procedure, the term "complaint" includes a mandatory report under RCW 18.130.070 and 18.130.080.
[2] Unprofessional conduct is defined in RCW 18.130.180.

2. *Anesthesiology Assistant Students*. In 2024, under authority of SB 5184, the AA profession was statutorily authorized and awaits rulemaking for implementation. Should an AA student have a complaint filed against them, the Commission's intent is to handle the complaint in a manner that complies with all applicable statutes and rules, and in a similar manner to how it handles PA and medical students.

~~1.~~ *MD Students.* ~~Medical~~ Under authority of RCW 18.71.030(8), MD students are ~~not required to have a license to practice medicine. They are~~ legally permitted to practice medicine in an accredited school of medicine without a license, so long as the practice is pursuant to a regular course of instruction or assignments from an instructor~~,~~ or performed under the supervision or control of a licensed physician.[3] ~~Since medical students are in the early stages of learning in a highly structured and supervised environment, the dean of the medical school is often better equipped to address a concern~~l ~~than the WMC~~

3. f, however, the Commission receives a complaint against an MD student involving the practice of medicine *outside* of their training program, or involving a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct, the Commission may choose to investigate the complaint. If an investigation leads to a finding of unprofessional conduct, and the Commission decides that discipline is necessary to protect the public, the Commission may impose discipline under authority of RCW 18.71.230.

B. *The Procedure to Handle Complaints against PA, AA, and MD Students.*

1. A panel of the Commission reviews a complaint against a student with applicable redactions to indicate their "student" status.
2. The panel may consider that the student is in training and whether the Commission is aware of previous complaints, and then may decide to proceed in the following manner:
    - Close the complaint;
    - Close the complaint and refer the complaint to the training program director or appropriate dean of their school;
    - Open an investigation and consider making a simultaneous referral to WPHP if a complaint includes that the student is impaired or potentially impaired as the result of a health condition; or
    - Open an investigation if the panel believes that the student may have engaged in a boundary violation, sexual misconduct, diversion of a medication or drug, reckless behavior, or gross misconduct, or if the student was convicted of a crime.

## ~~Residents~~Resident Complaints Prior to Full Physician and Surgeon Licensure

A. *Resident Complaints are generally Referred to Program Directors, with some Exceptions.* Under authority of RCW 18.71.030(9), residents are legally permitted ~~and fellows, who may or may not~~

[3] ~~Both residents and fellows are exempt from the license requirement under RCW 18.71.030(8) if they are in a program of clinical medical training sponsored by a college or university or hospital in this state and the performance of medical services are pursuant to their duties as residents and fellows. Although not required, many residents and fellows obtain a full license or a limited license under RCW 18.71.095(3) or (4)(b).~~

~~possess a license~~ to practice medicine in a training program sponsored by a college or university or a hospital in this state, pursuant to their duties as a trainee. Postgraduate clinical training programs generally require each of their residents to initially obtain a limited license which permits them to ~~,[4] do not~~ practice medicine in connection with their duties in the residency program, though many residents seek full physician and surgeon licensure as soon as~~independently. Rather,~~ they meet eligibility requirements which include the successful completion of two years of postgraduate training.

A limited license does not authorize a resident to engage in any practice of medicine outside of their residency program, but full licensure does. The Commission recognizes that residents practicing medicine *within* their program with a limited license have little control over their practice ~~in a learning~~ environment which, by design, provides ongoing learning opportunities with continuous evaluation and feedback ~~designed~~ processes to ~~develop~~ cultivate the skills necessary to be a competent physician. ~~An attending physician is~~ Attending physicians and program directors are responsible for training their residents ~~and fellows as to~~ on the ~~proper standards~~ standard of care and professional conduct involving the practice of medicine. Due to established supervisory roles within training programs, a residency program director, or alternatively an attending physician, graduate medical education officer, or hospital employer, may be~~appropriate behavior. The attending physician is therefore~~ in a better position than the Commission to manage concerns involving one of their residents. Before residents become fully licensed, they are generally not investigated or disciplined by the Commission, however, there are some exceptions.

1. *Unprofessional Conduct.* A limited license does not shield a resident, their supervising attending physician, or their program director from potentially being investigated or disciplined by the Commission if the Commission, on a case-by-case basis, determines that investigation or discipline is necessary to protect the public. If the Commission receives a complaint involving a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct by a resident with a limited license, the Commission may choose to investigate the complaint to protect the public. Further, the Commission may discipline a resident with a limited license for a finding of unprofessional conduct under authority of RCW 18.71.230.

~~A. than the WMC. If, however, a resident or fellow practices outside the program and independent of the supervision of the attending physician, such as in a moonlighting setting, the WMC is the appropriate entity to address concerns and take action if necessary.~~

~~B.~~2. *Health Condition Impairment.* Whether fully licensed as a physician and surgeon or not, if the Commission receives~~If~~ a complaint ~~that~~alleges that a resident is impaired~~or fellow engaged in reckless behavior~~ or potentially impaired as~~gross misconduct, the WMC may investigate~~ the result of a health condition,~~complaint against~~ the Commission~~resident or fellow, and~~ may ~~choose to~~ open an investigation and consider making a simultaneous referral to ~~on~~ the Washington Physician Health Program (WPHP). ~~attending physician as well.~~

~~[4] RCW 18.71.030(8).~~

~~A. Procedure~~

~~B. *Complaints against medical students*~~

~~C. A panel of the WMC reviews a complaint against a medical student.~~

~~D. The panel may close the case and refer the matter to the dean of the medical school in which the medical student is and/enrolled, unless the panel believes that the medical student may have engaged in reckless behavior or gross misconduct. In such a case, the panel may choose to investigate the complaint.~~

~~E.~~B. ~~C~~*Procedural Handling of C*omplaints *against Residents Prior to Full Licensure.~~*residents and fellows*~~

~~1.~~ If ~~A panel of the WMC reviews~~ a complaint is against a resident without a full physician and surgeon license, applicable redactions should indicate "resident" (rather than "respondent") to indicate their level of training~~or fellow~~.~~.~~

1.

2. A panel of the Commission reviews ~~If the panel believes there was a breach of the standard of care, but there was no gross negligence or other reckless behavior, the panel will change~~ the redacted complaint against ~~name of~~ the resident, may consider that~~case from~~ the resident is in training and whether~~or fellow to~~ the Commission is aware of previous complaints, and may decide to proceed in the following manner:
    - Close the complaint, with or without a referral to the Commission's Physician Support Program (PSP);
    - Close but refer the complaint to the residency program director;
    - Open an investigation and consider making a simultaneous referral to WPHP if a complaint includes that the resident is impaired or potentially impaired as the result of a health condition;~~name of the and/or~~
    - Open an investigation on the resident if the panel believes that the resident engaged in a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct, or the safety of the public warrants opening an investigation;
    - ~~2.~~ Open an investigation on the attending physician, and/or the residency program director if the panel believes that the standard of care was violated, and the safety of the public warrants opening such an investigation; or~~.~~
    - ~~3. If the panel believes that the resident or fellow engaged in reckless behavior or gross misconduct, the panel may decide to investigate the resident or fellow, and may open a new case and investigate the attending physician as well.~~
    - ~~4.~~ ~~If the panel believes that the resident or fellow was practicing without the supervision of a license supervisor in an approved training program, such as in a moonlighting environment, the panel will t~~Treat the resident ~~or fellow~~ as it would any other licensed physician. ~~I. f~~ the panel believes that the resident was practicing independently outside of their program and without the supervision of an attending physician or a licensed supervisor in an approved

training program (e.g., if the resident is practicing in a moonlighting environment), the panel ~~The panel~~ may decide to investigate the resident ~~or fellow~~ consistent with how it handles complaints against fully licensed physicians and ~~and~~ will not hold an ~~the~~attending ~~attending physician~~ or residency director responsible for the resident's actions ~~of the resident or fellow~~.

~~5.~~ If the Commission~~WMC~~ takes disciplinary action against the resident's attending physician or program director, the Commission~~WMC~~ may consider restricting them~~the attending physician~~ from ~~the~~ training medical students, ~~of~~ residents or fellows, though the Commission~~WMC~~ is not limited to this particular sanction.

~~3.~~

## Resident Complaints After Full Physician and Surgeon Licensure

*A. Fully Licensed Residents.*

Once a resident obtains full physician and surgeon licensure, even if they are performing duties within their residency program (e.g., not in a moonlighting setting), the Commission is generally the appropriate entity to address complaints and to take action if necessary.

Similarly, if a resident practices medicine outside of their program and independent of attending physician supervision (e.g., in a moonlighting setting), whether or not they are fully licensed to legally be authorized to do so, the Commission is generally the appropriate entity to address complaints and to take action if necessary.

*B. Procedure.*

1. Complaints filed against a resident with a full physician and surgeon license should be handled using the standard complaint process.
2. The standard complaint process includes redactions stating "respondent" (not "resident"), and their status of being a resident generally should not be considered in determining whether to open an investigation or impose discipline, however, the panel may exercise discretion on a case-by-case basis.

Reaffirmed / Updated: N/A

Supersedes: N/A

Procedure

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# Processing Complaints Against Students and Resident Physicians

## Introduction

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (Commission) occasionally receives complaints[1] against students and resident physicians (residents) while they are in training. Because of the highly supervised environment in which they are practicing medicine, the Commission provides practitioners (students, residents, and their supervising attending physicians and program directors) and the general public the following procedure on how complaints against residents and physician assistant (PA), anesthesiology assistant (AA), and allopathic medical (MD) students are handled.

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2. *Anesthesiology Assistant Students*. In 2024, under authority of SB 5184, the AA profession was statutorily authorized and awaits rulemaking for implementation. Should an AA student have a

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complaint filed against them, the Commission's intent is to handle the complaint in a manner that complies with all applicable statutes and rules, and in a similar manner to how it handles PA and medical students.

3. *MD Students.* Under authority of RCW 18.71.030(8), MD students are legally permitted to practice medicine in an accredited school of medicine without a license, so long as the practice is pursuant to a regular course of instruction or assignments from an instructor or performed under the supervision or control of a licensed physician. If, however, the Commission receives a complaint against an MD student involving the practice of medicine *outside* of their training program, or involving a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct, the Commission may choose to investigate the complaint. If an investigation leads to a finding of unprofessional conduct, and the Commission decides that discipline is necessary to protect the public, the Commission may impose discipline under authority of RCW 18.71.230.

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## Resident Complaints Prior to Full Physician and Surgeon Licensure

A. *Resident Complaints are generally Referred to Program Directors, with some Exceptions.* Under authority of RCW 18.71.030(9), residents are legally permitted to practice medicine in a training program sponsored by a college or university or a hospital in this state, pursuant to their duties as a trainee. Postgraduate clinical training programs generally require each of their residents to initially obtain a limited license which permits them to practice medicine in connection with their duties in the residency program, though many residents seek full physician and surgeon licensure as soon as they meet eligibility requirements which include the successful completion of two years of postgraduate training.

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and feedback processes to cultivate the skills necessary to be a competent physician. Attending physicians and program directors are responsible for training their residents on the standard of care and professional conduct involving the practice of medicine. Due to established supervisory roles within training programs, a residency program director, or alternatively an attending physician, graduate medical education officer, or hospital employer, may be in a better position than the Commission to manage concerns involving one of their residents. Before residents become fully licensed, they are generally not investigated or disciplined by the Commission, however, there are some exceptions.

1. *Unprofessional Conduct.* A limited license does not shield a resident, their supervising attending physician, or their program director from potentially being investigated or disciplined by the Commission if the Commission, on a case-by-case basis, determines that investigation or discipline is necessary to protect the public. If the Commission receives a complaint involving a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct by a resident with a limited license, the Commission may choose to investigate the complaint to protect the public. Further, the Commission may discipline a resident with a limited license for a finding of unprofessional conduct under authority of RCW 18.71.230.
2. *Health Condition Impairment.* Whether fully licensed as a physician and surgeon or not, if the Commission receives a complaint that that a resident is impaired or potentially impaired as the result of a health condition, the Commission may open an investigation and consider making a simultaneous referral to the Washington Physician Health Program (WPHP).

B. *Procedural Handling of Complaints against Residents Prior to Full Licensure.*

1. If a complaint is against a resident without a full physician and surgeon license, applicable redactions should indicate "resident" (rather than "respondent") to indicate their level of training.

2. A panel of the Commission reviews the redacted complaint against the resident, may consider that the resident is in training and whether the Commission is aware of previous complaints, and may decide to proceed in the following manner:
    - Close the complaint, with or without a referral to the Commission's Physician Support Program (PSP);
    - Close but refer the complaint to the residency program director;
    - Open an investigation and consider making a simultaneous referral to WPHP if a complaint includes that the resident is impaired or potentially impaired as the result of a health condition;
    - Open an investigation on the resident if the panel believes that the resident engaged in a boundary violation, sexual misconduct, diversion of a medication or drug, criminal conviction, reckless behavior, or gross misconduct, or the safety of the public warrants opening an investigation;
    - Open an investigation on the attending physician, and/or the residency program director if the panel believes that the standard of care was violated, and the safety of the public warrants opening such an investigation; or

- Treat the resident as it would any other licensed physician. If the panel believes that the resident was practicing independently outside of their program and without the supervision of an attending physician or a licensed supervisor in an approved training program (e.g., if the resident is practicing in a moonlighting environment), the panel may decide to investigate the resident consistent with how it handles complaints against fully licensed physicians and will not hold an attending or residency director responsible for the resident's actions.

3. If the Commission takes disciplinary action against the resident's attending physician or program director, the Commission may consider restricting them from training medical students, residents or fellows, though the Commission is not limited to this particular sanction.

## Resident Complaints After Full Physician and Surgeon Licensure

*A. Fully Licensed Residents.*

Once a resident obtains full physician and surgeon licensure, even if they are performing duties within their residency program (e.g., not in a moonlighting setting), the Commission is generally the appropriate entity to address complaints and to take action if necessary.

Similarly, if a resident practices medicine outside of their program and independent of attending physician supervision (e.g., in a moonlighting setting), whether or not they are fully licensed to legally be authorized to do so, the Commission is generally the appropriate entity to address complaints and to take action if necessary.

*B. Procedure.*

1. Complaints filed against a resident with a full physician and surgeon license should be handled using the standard complaint process.
2. The standard complaint process includes redactions stating "respondent" (not "resident"), and their status of being a resident generally should not be considered in determining whether to open an investigation or impose discipline, however, the panel may exercise discretion on a case-by-case basis.

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| Date of Adoption: | July 10, 2020 |
| Reaffirmed / Updated: | N/A |
| Supersedes: | N/A |

# Policy

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| | | |
|---|---|---|
| Title: | Commissioner and Pro Tem Recusal Policy to Address Conflicts of Interest | POL202x-0x |
| References: | | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@wmc.wa.gov |
| Supersedes: | NA | |
| Effective Date: | | |
| Approved By: | ,Chair | |

## Introduction

Administrative proceedings are to be free from the impression that a participating member pre-judged the matter at hand. In *Washington Med. Disciplinary Bd. v. Johnston*, the Supreme Court of Washington opined, "Under the appearance of fairness doctrine, proceedings before a quasi-judicial tribunal are valid only if a reasonably prudent and disinterested observer would conclude that all parties obtained a fair, impartial, and neutral hearing." [1]

Similarly, the Washington State Executive Ethics Board has issued advisory opinions regarding the Ethics in Public Service Act, Chapter 42.52 of the Revised Code of Washington (RCW), and its application to Boards/Commissions. That guidance has remained grounded in the basic concept that public servants are not to be decision-makers involving matters that personally benefit them. Advisory Opinion number 96-09 includes that boards and commissions may require members to disclose their interests and abstain from voting or attempting to influence votes when there is a conflict of interest.[2]

In compliance with the advisory opinion, the Washington Medical Commission (Commission) Code of Conduct states that commissioners will, "recuse themselves and proactively disclose when there is a real or potential conflict of interest, or the appearance of such a conflict." This code of conduct aligns with the Federation of State Medical Boards (FSMB) recommendation that boards adopt a conflict of interest policy. Such a policy should include that no board member shall participate in the deliberation, making of any decision, or taking of any action affecting the member's own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate.

[1] *Matter of Johnston, 99 Wash. 2d 466, 478, 663 P.2d 457, 464 (1983).*
[2] Advisory Opinion on Disclosure Requirements for Boards and Commissions, Number 96-09, approved May 20, 1996, reviewed May 5, 2021, available at https://ethics.wa.gov/sites/default/files/public/AO%2096-09.pdf (Accessed April 8, 2024)

The Commission is committed to preventing bias from unjustly influencing Commission activities. The purpose of this policy is to prevent biases from unjustly impacting licensing, investigations, policy-making, and disciplinary matters. To further prevent bias from impacting Commission activities, the Commission redacts practitioner (allopathic physician or physician assistant) identifying information including, but not limited to, name, gender or gender identity, and race on applications and complaints. While redactions are intended to prevent bias and to ensure fairness, they may unintentionally contribute to a commissioner not immediately recognizing a conflict of interest. Once a commissioner or the Commission Executive Director becomes aware of a possible conflict of interest involving a commissioner, this recusal policy provides guidance to proceed in a manner that avoids potential bias from compromising fundamental fairness.

This policy is intended to provide guidance for commissioners and pro tem appointees[3] to prevent conflicts of interest from potentially compromising fundamental fairness in the handling of Commission matters.

## Legal Authority

### *United States Constitution*

The 14th Amendment of the United States Constitution,[4] provides due process protection for individuals in the U.S., not just practitioners, to protect against biased, unjust governmental adjudications. The United States Supreme Court has clarified that due process protects against a likelihood of decision-maker bias from impacting a fair adjudication,[5] and these protections have been further enhanced through Washington state laws.

### *Revised Code of Washington*

In Washington, commissioners are considered "state officers", and as such are bound by the Ethics in Public Service Act, chapter 42.52 RCW. Pertinent sections of this statute include the following:

> **RCW 42.52.020 Activities incompatible with public duties.**
>
> No state officer or state employee may have an interest, financial or otherwise, direct or indirect, or engage in a business or transaction or professional activity, or incur an obligation of any nature, that is in conflict

[3] To void redundancy, the term "commissioner" henceforth includes a commissioner or a pro tem appointee.

[5] "Not only is a biased decisionmaker constitutionally unacceptable, but 'our system of law has always endeavored to prevent even the probability of unfairness.' Where there is merely a general predilection toward a given result which does not prevent the agency members from deciding the particular case fairly, however, there is no deprivation of due process." *Matter of Johnston*, 99 Wash. 2d 466, 475, 663 P.2d 457, 462 (1983) (quoting *In re Murchison,* 349 U.S. 133, 136 (1955)).

with the proper discharge of the state officer's or state employee's official duties.

**RCW 42.52.030 Financial interests in transactions.**

(1) No state officer or state employee, except as provided in subsection (2) of this section, may be beneficially interested, directly or indirectly, in a contract, sale, lease, purchase, or grant that may be made by, through, or is under the supervision of the officer or employee, in whole or in part, or accept, directly or indirectly, any compensation, gratuity, or reward from any other person beneficially interested in the contract, sale, lease, purchase, or grant.

**RCW 42.52.160 Use of persons, money, or property for private gain.**

(1) No state officer or state employee may employ or use any person, money, or property under the officer's or employee's official control or direction, or in his or her official custody, for the private benefit or gain of the officer, employee, or another.

**RCW 42.52.903 Serving on board, committee, or commission not prevented.**

Nothing in this chapter shall be interpreted to prevent a member of a board, committee, advisory commission, or other body required or permitted by statute to be appointed from any identifiable group or interest, from serving on such body in accordance with the intent of the legislature in establishing such body.

## Guidance on Transparency Involving a Conflict of Interest and Recusal

There must be transparency in the handling of conflicts of interests involving Commission matters. To prevent a conflict of interest involving public duties from compromising fairness, the Commission recognizes that specific prohibitions in chapter 42.52 RCW must be read in conjunction with the exception specified in RCW 42.52.903 and, in limited circumstances, that conflicts of interest may occasionally be unavoidable. A commissioner's employer or affiliated health systems may not, in and of themselves, create a conflict of interest necessitating recusal; however, when any of these affiliations, or others, create a scenario in which that a commissioner may financially, personally, or professionally benefit, or be harmed, that does necessitate recusal.

The Commission adopts the following guidance:

- Commissioners are responsible for handling conflicts of interest with full transparency at all times and for recusing themselves from cases as soon as reasonably possible if

they recognize a conflict of interest that may compromise fairness, impartiality, or the appearance of impartiality;

- No commissioner may be beneficially interested, directly or indirectly, in a decision in which they are involved;
- No commissioner may participate, in their official capacity, in a transaction involving the state with a partnership, association, corporation, firm or other entity of which the commissioner is an officer, agent, employee or member, or in which the commissioner owns a beneficial interest;
- A commissioner is encouraged to announce their potential conflict of interest and recuse themselves as soon as they first recognize the potential conflict, and if there is a true conflict they should leave the room or call and not participate in any discussion involving the matter to avoid impartiality or the appearance of impartiality; and
- A commissioner must abstain from any discussion or vote taken by the Commission involving an action (including contracting, rulemaking, or policy decisions) or transaction with any entity with which the commissioner may benefit or be harmed (financially, personally, or professionally), and if a commissioner abstains from voting because of such involvement, such commissioner shall announce for the record their reason for their abstention.
- **Table 1** should be used as a guide by a commissioner to determine whether a given scenario is a (1) must disclose and recuse, (2) should disclose and recuse, or (3) should disclose but unnecessary to recuse situation.

**Table 1**

| ***Situation*** | **CMT** | **RCM** | **Disposition Panel** | **Hearing Panel** |
|---|---|---|---|---|
| *Vaguely know of the patient or respondent or opposing counsel or expert witness* | Should Disclose but unnecessary to recuse | Should Disclose but unnecessary to recuse | Should Disclose but unnecessary to recuse | Should Disclose but unnecessary to recuse |
| *Any current or past relationship* with the patient or respondent* | Must | Must | Must | Must |
| *Previous or outside awareness of the incident that is the basis of the complaint* | Must | Must | Must | Must |
| *Work at the same facility where the incident(s) occurred that form the basis for the complaint* | Should | Should | Should | Should |
| *Work in the same hospital/healthcare system where the incident(s) occurred that form the basis for the complaint* | Should | Should | Should | Should |
| *A relationship* with opposing counsel* | Should | Should | Should | Should |
| *Any current or past relationship* with an expert or fact witness* | Must | Must | Must | Must |
| *Current or past attorney of record for the applicant or respondent* | Must | Must | Must | Must |
| *Any financial risk or benefit to self or someone the commissioner has a current or prior relationship with related to the case* | Must | Must | Must | Must |

***A relationship includes, but is not limited to, friends, family, coworkers, and **individuals involved in the same** joint venture, business transaction, or lawsuit.*

## Procedure for Commissioner Recusal[6]

### Internal Process Among Commissioners

To ensure fundamental fairness, a commissioner should notify the Panel Chair and the Executive Director of any concerns they have regarding any commissioner's, including but not limited to their own, inability to be impartial. Disqualification processes and standards are addressed in the Administrative Procedure Act, specifically in RCW 34.05.425[7], in addition to the Model Procedural Rules for Boards, specifically in WAC 246-11-230[8].

### Standards for Recusal

A commissioner should exercise sound discretion in choosing whether to be recused from participation and voting regarding any matter. A commissioner should choose to be recused if they:

- Have a direct financial interest or relationship with any matter, party, or witness that would give the appearance of a conflict of interest;
- Have a current or past familial relationship within the third degree of affinity with any party or witness; or
- Determine that they have knowledge of information that is not in the administrative record of a contested case and that they cannot set aside that knowledge and fairly and impartially consider the matter based solely on the administrative record.

Once a commissioner believes there may be a conflict of interest that has the potential to cause impartiality, or an appearance of impartiality, the first step is for the commissioner who recognizes that conflict to alert the Commission Executive Director, or their designee. Then, in consultation with the Commission Executive Director, or their designee, there will be a discussion with the commissioner with the potential conflict, if possible, to make a clear determination of the following: (1) "must" recuse, (2) "should" recuse, or (3) "unnecessary" to

[6] This recusal procedure was heavily influenced by Texas Administrative Code, Rule Section 187.42, with quotation marks omitted, with modifications which incorporate Washington state law and ethics board guidance to ensure impartiality and to protect the public.

[7] "(3) Any individual serving or designated to serve alone or with others as presiding officer is subject to disqualification for bias, prejudice, interest, or any other cause provided in this chapter or for which a judge is disqualified. (4) Any party may petition for the disqualification of an individual promptly after receipt of notice indicating that the individual will preside or, if later, promptly upon discovering facts establishing grounds for disqualification. (5) The individual whose disqualification is requested shall determine whether to grant the petition, stating facts and reasons for the determination. (6) When the presiding officer is an administrative law judge, the provisions of this section regarding disqualification for cause are in addition to the motion of prejudice available under RCW 34.12.050. (7) If a substitute is required for an individual who becomes unavailable as a result of disqualification or any other reason, the substitute must be appointed by the appropriate appointing authority. (8) Any action taken by a duly appointed substitute for an unavailable individual is as effective as if taken by the unavailable individual." RCW 34.05.425.

[8] "(4) Any party may move to disqualify the presiding officer, or a member of the board hearing the matter, as provided in RCW 34.05.425(3)." WAC 246-11-230.

recuse. The determination will err on the side of recusal. If a conflict is recognized late, it will be addressed as soon as reasonably possible.

The fact that a commissioner participated in another matter regarding a respondent, applicant, attorney, or matter may not by itself mandate the commissioner's recusal from other matters. If a commissioner is familiar with a respondent or applicant due to serving on a panel or serving as a reviewing commission member, that alone is generally not sufficient to warrant recusal. However, in the event that prior involvement may potentially prejudice the rights of any party to a fair proceeding, the presiding officer (presiding commissioner or health law judge) may cure any such prejudice by an instruction to commissioners or members of the hearing panel to not consider the statement during the course of the proceeding or during deliberations or discussion related to the proceeding.

However, if the commissioner has prior knowledge of a situation from having served as a hospital quality assurance reviewer or as an expert or fact witness or attorney of record on a civil case involving the respondent or applicant, recusal is warranted.

In summary, commissioners must recuse themselves if there is a conflict of interest and should recuse if there is an appearance of a conflict of interest. Commissioners are expected to use reasonable judgment and should discuss possible conflicts of interest with the Commission Executive Director, or their designee, and err on the side of recusal.

# Policy

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| | | |
|---|---|---|
| Title: | Artificial/Assistive Intelligence (AI) Policy | POL202x-0x |
| References: | | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@wmc.wa.gov |
| Supersedes: | NA | |
| Effective Date: | | |
| Approved By: | ,Chair | |

## Introduction

The Washington Medical Commission (Commission) provides practitioners (physicians, physician assistants, and anesthesiologist assistants) this policy to address the use of artificial/assistive/ augmented intelligence (AI) in their delivery of health care in the state of Washington. The Commission recognizes the need for practitioners to understand how AI tools may be used safely in their practices while AI technology continues to evolve. It is estimated that medical knowledge doubles every 73 days,[1] that 30 percent of all the data generated worldwide is estimated to be health care related,[2] and that AI may help to revolutionize the practice of medicine by assisting practitioners with their healthcare delivery and data integration into electronic health records.[3]

While definitions involving AI continue to evolve, Executive Order 14110 issued by the President of the United States in the fall of 2023 defined AI as follows:

> The term "artificial intelligence" or "AI" has the meaning set forth in 15 U.S.C. 9401(3): a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments. Artificial intelligence systems use machine- and human-based inputs to perceive real and virtual environments; abstract such perceptions into

[1] Densen, P. Challenges and opportunities facing medical education. Trans. Am. Clin. Climatol. Assoc. 122, 48 (2011).
[2] RBC Capital Markets Episode 1: The Healthcare Data Explosion, available at https://www.rbccm.com/en/gib/healthcare/episode/the_healthcare_data_explosion (Accessed May 6, 2024).
[3] Alanazi A. Clinicians' Views on Using Artificial Intelligence in Healthcare: Opportunities, Challenges, and Beyond. Cureus. 2023 Sep 14;15(9):e45255. doi: 10.7759/cureus.45255. PMID: 37842420; PMCID: PMC10576621, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10576621/ (Accessed May 6, 2024).

models through analysis in an automated manner; and use model inference to formulate options for information or action.[4]

Federal regulators recognize that AI has the potential to improve patient care, augment practitioner capabilities, and advance medical product development,[5] and the Commission concurs. As AI in healthcare continues to evolve, the Commission provides this summary of responsibilities, risks, benefits, and accountability considerations involving practitioners and the use of AI in their practice of medicine.

## Policy Statement

The Commission policy relating to the incorporation and use of AI tools in the practice of medicine is grounded in the following principles: (1) mutual informed consent, and (2) autonomy of the practitioner. AI may be used as a tool in the practice of medicine by practitioners. Regardless of whether the practitioner is receiving trend analysis or algorithm treatment recommendations, the practitioner is to remain directly involved in the care of the patient with one exception. The practitioner may participate in quality assurance reviews of AI tools while remaining uninvolved in direct patient care so long as they stay within the guardrails of evaluating for risk, safety, bias, and effectiveness of the AI tools themselves. However, prior to the use of AI involving a patient's care, the following should occur:

1. *Mutual Informed Consent.* Generally, when reasonably possible, the patient or the patient's authorized representative should provide consent for the use of AI that may be involved in their healthcare. That consent should include a specific discussion, either with the practitioner or designee, about the AI tool and how it may be used and not simply buried within a blanket consent document. Similarly, the practitioner should consent to the use of AI in their workflow and in their delivery of healthcare for it to be used.
2. *Autonomy of the Practitioner.* To be practicing within the standard of care using AI in the practice of medicine, a practitioner must have the expertise to assess, diagnose, and treat the patient in front of them, and, additionally, should understand the risks and benefits of using AI for the specific function(s) for which it is to be used. Practitioners may not use AI to expand their scope or specialty if they would not be competent to practice in that area of medicine without the use of an AI tool.
3. *Understanding Limitations and Education.* The practitioner is encouraged to complete continuing medical education (CME), including self-directed CME, to understand the impact of bias, in addition to limitations in research, involving underrepresented populations in health care technology applications such as AI. Prior to using a specific AI tool, the practitioner should understand limitations including but not limited to the potential for bias against populations that were not adequately represented in testing of AI tools to prevent patient harm.

[4] Executive Order 14110 "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence," Section 3(b), issued on October 30, 2023, and published in the Federal Register on November 1, 2023. Available at https://www.federalregister.gov/documents/2023/11/01/2023-24283/safe-secure-and-trustworthy-development-and-use-of-artificial-intelligence (Accessed May 6, 2024).

[5] Artificial Intelligence & Medical Products: How CBER, CDER, CDRH, and OCP are Working Together AI Medical Products Paper (fda.gov)

## State and National Considerations

The Federation of State Medical Boards (FSMB) provided guidance in April of 2024 to state medical boards, which includes the Commission, to help ensure the safe and effective use of AI to improve patient care. The FSMB guidance document, adopted by the FSMB House of Delegates, is entitled "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," which incorporated input provided by the FSMB Ethics and Professionalism Committee. FSMB's guidance on the use of AI in the practice of medicine includes the following:

> Artificial Intelligence (AI) holds tremendous potential to aid healthcare providers in diagnosis, treatment selection, clinical documentation, and other tasks to improve quality, access, and efficiency. However, these technologies introduce risks if deployed without proper "guardrails" and understanding which may impact considerations in clinical practice as well as regulatory processes of state medical boards. By taking a proactive and standardized governance approach anchored in ethical principles, state medical boards can promote safe and effective integration of AI, in its various forms, while prioritizing patient wellbeing.[6]

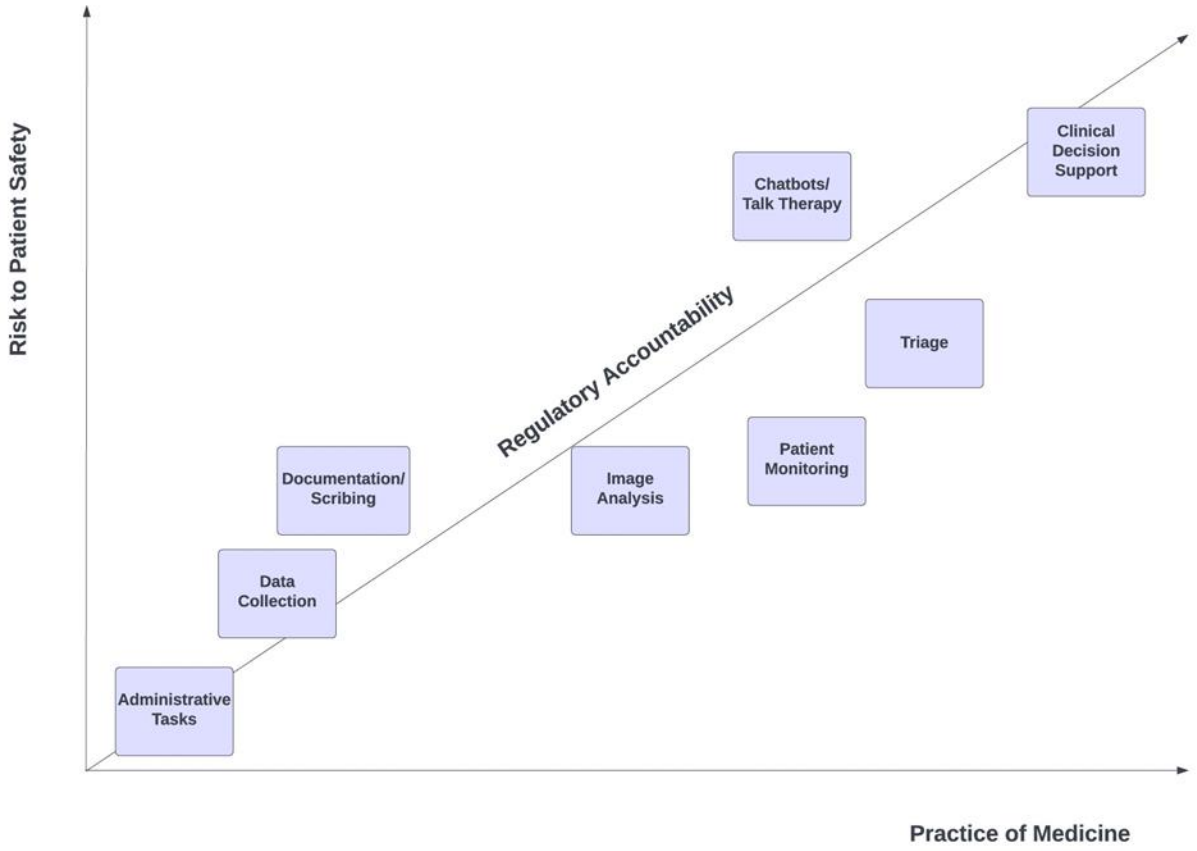
As described in the FSMB guidance, multiple AI applications are already being used in healthcare "to analyze large datasets to identify patterns, classify information, and make predictions to support clinical decision-making."[7] While still evolving, AI technology is currently being used in healthcare in the following manner:

- Analyzing medical images thru computer vision systems,
- Reviewing medical records to improve communication thru interpretive services,
- Forecasting clinical trends using predictive algorithms and advanced data analytics,
- Supporting provider medical record documentation thru voice recognition, and
- Providing patient triage and education using "Chatbots."[8]



[6] "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p.1, available at incorporation-of-ai-into-practice.pdf (fsmb.org)
[7] "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p.3, available at incorporation-of-ai-into-practice.pdf (fsmb.org)
[8] "Navigation the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p. 3, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

The FSMB guidance described numerous benefits of the use of AI in the practice of medicine while also providing guidance on regulatory accountability to limit risk. The following graph visualizes how AI usage in areas of medical practice correlates with risk ratios and a corresponding need for regulatory accountability.[9]




In the state of Washington, Governor Jay Inslee on January 30, 2024, issued Executive Order 24-01 on Artificial Intelligence, and defined the following terminology:

1. "Generative AI Technology" is a technology that can create content, including text, images, audio, or video, when prompted by a user. Generative AI systems learn patterns and relationships from large amounts of data, which enables systems to generate new content that may be similar, but not identical, to the underlying training data.

2. "High-Risk Generative AI System" means systems using generative AI technology that creates a high risk to natural persons' health and safety or fundamental rights. Examples include biometric identification, critical infrastructure, employment, health care, law enforcement, and administration of democratic processes.

[9] "Navigation the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p. 6, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

Additional definitions that aide in understanding this topic are as follows:

> "Artificial intelligence" means any technology that can simulate human intelligence, including but not limited to, natural language processing, training language models, reinforcement learning from human feedback and machine learning systems.
>
> "AI-generated content" shall mean image, video, audio, print or text content that is substantially created or modified by a generative artificial intelligence system such that the use of the system materially alters the meaning or significance that a reasonable person would take away from the content.[10]
>
> "Generative artificial intelligence system" shall mean any system, tool or platform that uses artificial intelligence to generate or substantially modify video, audio, print or text content.[11]
>
> "Metadata" shall mean structural or descriptive information about data such as content, format, source, rights, accuracy, provenance, frequency, periodicity, granularity, publisher or responsible party, contact information, method of collection, and other descriptions.[12]

Generative AI Technology and High-Risk Generative AI Systems are being developed rapidly in the healthcare arena. AI technological advances may create educational, privacy, and use-related challenges for practitioners. As AI technology continues advancing, practitioners must ensure that their use, or their lack thereof, of AI in the practice of medicine complies with evolving standards of care involving ethics and equity, decision making, and information management.

## Standards of Care: Ethics and Equity Principles, Decision Making Influences, and Information Management Responsibilities

*A. Ethical and Equity Principles.*

The Commission ensures the ethical and equitable delivery of healthcare by practitioners, whether or not AI is being utilized, to protect patient safety. The Commission adopts the following FSMB's guidance involving bias:

> AI systems encumbered by false or inaccurate information may carry a bias that can be detrimental to providers and harmful to patients. The principle of justice dictates that physicians have a professional responsibility to identify and eliminate biases in their provision of patient care, including those that may arise through biased AI algorithms. AI also poses an opportunity to expand access to care for populations historically marginalized and otherwise disadvantaged.

[10] Commonwealth of Massachusetts HD 4788. Similarly, the Commission recognizes this definition in the state of Washington.
[11] Commonwealth of Massachusetts HD 4788. Similarly, the Commission recognizes this definition in the state of Washington.
[12] Commonwealth of Massachusetts HD 4788 (applying the definition from 44 U.S.C.A. Section 3502(19)). Similarly, the Commission recognizes this definition in the state of Washington.

> Efforts must be made to ensure that all patients have equitable access to the benefits of AI and that existing disparities are not further exacerbated.[13]

The principle of justice dictates that physicians have a professional responsibility to identify and eliminate biases, including avoiding the use of biased AI algorithms which may increase the risk of patient harm, in their practice of medicine.

*B. Informed Consent involving Decision-Making Influences.*

Any practitioner using AI in the practice of medicine should obtain informed consent from the patient, or the patient's authorized representative, in advance of the use of AI in their treatment and provide them with the option to receive treatment without the use of AI. Any AI system used in the practice of medicine must be designed to prioritize the safety and well-being of individuals seeking treatment and remain monitored by a practitioner to ensure its safety and effectiveness.[14]

The Commission adopts the following FSMB's guidance on AI decision-making influences:

> Physicians may consider AI as a decision-support tool that assists, but does not replace, clinical reasoning and discretion. Physicians should understand the AI tools they are using by being knowledgeable about their design, training data used in its development, and the outputs of the tool in order to assess reliability and identify and mitigate bias. Once the treating physician chooses to use AI, they accept responsibility for responding appropriately to the AI's recommendations. For example, if a physician chooses to follow the course of treatment provided by an AI-generated response, then they should be prepared to provide a rationale for why they made that decision. Simply implementing the recommendations of the AI without a corresponding rationale, no matter how positive the outcome may be, may not be within the standard of care. Alternatively, if the physician uses AI and then suggests a course of treatment that deviates from one delineated by AI, they should document the rationale behind the deviation and be prepared to defend the course of action should it lead to a less than optimal or harmful outcome for the patient. Generally, the reason a physician provides for disagreeing with an AI's recommendation should be because following that recommendation would not uphold the standard of care. As with any tool, once it produces a result, the outcomes cannot be ignored; there must be documentation reflecting how it was or will be utilized by the physician in the care provided. While the expanded use of AI may benefit a physician, failure to apply human judgement to any output of AI is a violation of a physician's professional duties.[15]



[13] "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p. 8, available at incorporation-of-ai-into-practice.pdf (fsmb.org)
[14] Modified wording with quotations omitted from wording within the Commonwealth of Massachusetts H.1974.
[15] "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p.6, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

C. *Information Management Responsibilities.*

1. Protecting Privacy.

The use of AI neither decreases a practitioner's duty to protect privacy, nor alters the basic purpose of patient medical records. Practitioners are encouraged to ensure they understand the Commission's Guidance Document of Medical Records.

2. Documentation.

The Commission recommends, but does not require, that practitioners practicing medicine in the state of Washington do the following involving the documentation of their AI use.

> Each generative artificial intelligence system used to create audio, video, text or print AI-generated content should include on or within such content a clean and conspicuous disclosure that meets the following criteria: (i) a clear and conspicuous notice, as appropriate for the medium of the content, that identifies the content as AI-generated content, which is to the extent technically feasible, permanent or uneasily removed by subsequent users; and (ii) metadata information that includes an identification of the content as being AI-generated content, the identity of the system, tool or platform used to create the content, and the date and time the content was created.[16]

## Conclusion

This policy seeks to ensure the responsible incorporation and use of AI tools by practitioners in the practice of medicine. AI holds promise of benefitting patients and practitioners; however, irresponsible use will raise the risk of patient harm. Practitioners are encouraged to participate in continuing medical education to gain awareness of the evolving risks, benefits, and alternatives of the use of AI technologies in healthcare. In general, honoring professional standards involving ethics, equity, informed consent, privacy, and documentation will help to minimize the risks to practitioners and the patients that they treat as this technology continues to evolve.



[16] Adapted from the Commonwealth of Massachusetts HD 4788. The Commission recognizes this guidance as a best practice in the state of Washington but not a requirement.

# Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

**To:** **Policy Committee**

**From:** **Pam Kohlmeier, MD, JD**
**Policy Manager**

**Subject:** **Recommendation to Rescind the Commission's Telemedicine Policy**

The state of Washington became the first state to enact ESSB 5481, the Uniform Telemedicine Act, and this statute just recently went into effect on June 6, 2024. As such, the Commission's Telemedicine policy POL2021-02 became superseded by statutory law. Therefore, the Commission's Telemedicine policy should be rescinded.

Incidentally, that telemedicine policy has a short section at the tail end of it addressing the use of artificial intelligence (AI) in the practice of medicine. That short section was an attempt to address the bare bones regulation of this rapidly evolving tool in medicine. By rescinding the Telemedicine policy, it is timely that the Policy Committee is considering a recommendation to adopt the new Artificial Intelligence (AI) policy that is on the Policy Committee agenda today.

As the Policy Manager, I am recommending that you vote to rescind the Commission's Telemedicine Policy POL2021-02, whereas the policy is now superseded by statute.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

*Olympia, Washington 98504*

# NOTICE OF ADOPTION OF A POLICY STATEMENT

**Title of Policy Statement:** Telemedicine | Policy Number: POL2021-02

**Issuing Entity:** Washington Medical Commission

**Subject Matter:** Defining and providing guidance on Telemedicine usage.

**Effective Date:** November 19, 2021

**Contact Person**: Michael Farrell, JD
Policy Development Manager
16201 E Indiana Avenue
Suite 1500
Spokane Valley, WA 99203
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michael.farrell@wmc.wa.gov

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 12, 2021
TIME: 4:54 PM

WSR 22-01-092

# Policy Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| | | |
|---|---|---|
| Title: | Telemedicine | POL2021-02 |
| References: | Chapter 18.71B RCW; RCW 18.71.011; RCW 18.71.030(6); chapter 18.71A RCW; RCW 7.70.050(4); RCW 18.71.220; RCW 26.44.056; chapter 70.02 RCW | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@wmc.wa.gov |
| Supersedes: | MD2014-03; POL2018-01 | |
| Effective Date: | November 19, 2021 | |
| Approved By: | John Maldon, Chair (signature on file) | |

## Introduction

The Washington Medical Commission (Commission) endorses the use of telemedicine as a tool that has the potential to increase access, lower costs, and improve the quality of healthcare. The Commission issues this policy statement to provide guidance to allopathic physicians and physician assistants (practitioners) who use telemedicine to provide medical services to Washington patients. This policy specifies the conditions under which a license is needed to use telemedicine to treat a patient in Washington and delineates best practices when using telemedicine to ensure that patients receive safe and appropriate care.

In 2014, the Commission issued Guidelines for the Appropriate Use of Telemedicine (MD2014-03), establishing general practice standards for practitioners and initiating a patient-practitioner relationship using telemedicine. In 2018, the Commission issued a policy on Telemedicine and Continuity of Care (POL2018-01). This policy supersedes both the 2014 guidelines and the 2018 policy.

In 2017, Washington joined the Interstate Medical Licensure Compact (compact). The compact, now in place in a majority of states, is intended to facilitate licensure for physicians who practice in multiple states, allowing patients in underserved areas to more easily connect with medical experts through telemedicine technologies.[1]

## Policy

### Definition of Telemedicine

For the purposes of this policy, the Commission defines telemedicine as a mode of delivering healthcare services using telecommunications technologies by a practitioner to a patient or to

[1] Chapter 18.71B RCW. For information on the compact, see http://www.imlcc.org/

consult with another health care provider at a different physical location than the practitioner. Telemedicine includes real-time interactive services, store-and-forward technologies, and remote monitoring.

Store-and-forward technology is the asynchronous or non-simultaneous transmission of a patient's medical information from an originating site to the health care provider at a distant site that results in examination, medical diagnosis, or treatment of the patient. Remote monitoring involves the use of digital technology to collect health data from a patient in one location and electronically transmit that information securely to a health care provider in another location for evaluation and treatment decisions.

## Washington State Licensure Requirements for use of Telemedicine

The Commission deems the practice of medicine[2] to take place at the location of the patient at the time of the encounter.[3] Therefore, with a few exceptions detailed below, a practitioner engaging in the practice of medicine with a patient located in Washington must hold an active license to practice medicine in Washington.[4]

A practitioner licensed in Washington need not reside in Washington to use telemedicine to treat a patient in Washington. A practitioner licensed in Washington who wishes to treat a patient in another state will likely need a license to practice medicine in that state. The practitioner should contact the other state's medical board to find out the requirements for treating patients in that state.

### Exemptions to Washington State Licensure Requirements

The Commission recognizes several exceptions to the general rule that a practitioner is required to have a license when treating a patient in Washington. The legislature created a specific exemption to the licensure requirement for telemedicine practitioner-to-practitioner consultations. The consultation exemption permits a practitioner licensed in another state in which the practitioner resides to use telemedicine or other means to consult with a Washington licensed practitioner who remains responsible for diagnosing and treating the patient in Washington.[5] The law does not require real time communication between practitioners.

Another circumstance in which the Commission does not require a license is when a patient seeks a second opinion or a consultation with a specialist out of state, such as a cancer center, and sends medical records to the specialist to review and provide input on treatment. In this case, the specialist in the distant state does not need a license to practice medicine in Washington to review the records and provide an opinion, but not treatment, regarding the patient's care. The specialist may communicate that opinion directly with the patient. The patient may then choose to travel to see the distant practitioner for treatment or may choose

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[2] The practice of medicine is defined in RCW 18.71.011 .

[3] RCW 18.71B.010.

[4] The performance of medical interpretation services by rendering a diagnosis based on examination of radiologic imaging studies, tissue specimens or bodily fluid specimens for a patient located in Washington is the practice of medicine in Washington and therefore requires a license in Washington.

[5] RCW 18.71.030(6)

to have the specialist coordinate care with a Washington-licensed physician under the statutory exemption described above.

Another common situation that is not specifically addressed by a statutory exemption is when a patient with an established relationship with a practitioner licensed in another state crosses the border into Washington and requires medical care. In some cases, permitting the physician in the patient's home state to provide temporary continuous care is in the patient's best interest. This can arise in several common scenarios.

In the first scenario, a patient with an established relationship with a practitioner in the patient's home state travels to Washington for a limited time (e.g., vacation, business, or education) and requires medical care. The patient's out-of-state practitioner may be the best person to provide care via telemedicine while the patient is temporarily in Washington. If the practitioner knows that the patient will be residing in Washington for an extended period, the practitioner should develop a plan for emergent treatment agreed to by the patient. This may include a referral to a hospital or to a local specialist who can step in and assist in the case of devolving medical or mental status.

In the second scenario, a patient who is receiving treatment for a condition by a practitioner in a distant state moves to Washington and requires immediate medical care for that condition but has not yet established a relationship with a Washington practitioner. For example, a patient receiving psychiatric care and medication management from a psychiatrist in their former state may have difficulty finding a psychiatrist in Washington. Temporary care lasting up to 12 months via telemedicine by the patient's established psychiatrist may be in the patient's best interest until the patient can find a Washington-licensed practitioner to take over the care.

In the third scenario, a Washington resident travels to a distant state to obtain specialty care at a major medical center, then returns home to Washington. The patient may prefer to directly consult via telemedicine with the specialists who provided treatment to the patient in the distant state. Requiring the patient to travel back to the major medical center to receive follow up care could impose an unreasonable hardship on the patient. Permitting the practitioner at the major medical center to provide follow up care via telemedicine is the most optimal treatment plan for the patient.

In each of these cases, the patient needs are best served by having the practitioner who knows the patient and has access to the patient's medical records provide limited follow up care to the patient. So long as the out-of-state practitioner provides temporary continuity of care to the patient, the practitioner would not require a Washington license.

## Standard of Care and Best Practices When Using Telemedicine

The Commission offers the following guidance to practitioners providing medical services using telemedicine to ensure that patients receive safe and appropriate care:

The Commission will hold a practitioner who uses telemedicine to the same standard of care and professional ethics as a practitioner using a traditional in-person encounter with a patient.

The failure to follow the appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the Commission.

### Scope of practice

A practitioner who uses telemedicine should ensure that the services provided are consistent with the practitioner's scope of practice, including the practitioner's education, training, experience, and ability.

### Identification of patient and practitioner

A practitioner who uses telemedicine should verify the identity of the patient and ensure that the patient can verify the identity, licensure status, and credentials of all health care providers who participate in the telemedicine encounter.

### Establishing the Practitioner-patient relationship

A practitioner who uses telemedicine must establish a valid practitioner-patient relationship with the person who receives telemedicine services. The relationship is established when the practitioner agrees to undertake diagnosis or treatment of the patient and the patient agrees that the practitioner will diagnose or treat the patient. A valid practitioner-patient relationship may be established through telemedicine if the standard of care does not require an initial in-person encounter.

### Medical history and physical examination

Prior to providing treatment, including issuing prescriptions, a practitioner who uses telemedicine should interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. A practitioner may not delegate an appropriate history and physical examination to an unlicensed person or to a licensed individual for whom that function would be out of the scope of the license.

Once a practitioner has obtained a relevant medical history and performed a physical examination, it is within the practitioner's judgment to determine whether it is medically necessary to obtain a history or perform a physical examination at subsequent encounters. The technology used in a telemedicine encounter must be sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person by the practitioner. An on-line questionnaire does not constitute an acceptable medical interview for the provision of treatment, including issuance of prescriptions, by a practitioner. The standard of care requires direct interaction with a licensed practitioner.

### Appropriateness of telemedicine

Only the treating practitioner may determine if telemedicine is appropriate for a given patient encounter. A practitioner should consider the patient's health status, specific health care needs, and specific circumstances, and use telemedicine only if the risks do not outweigh the potential benefits and it is in the patient's best interest. If a practitioner determines that the use of telemedicine is not appropriate, the practitioner should advise the patient to seek in-person care.

### Informed consent

A practitioner who uses telemedicine should ensure that the patient provides appropriate informed consent, whether oral or written, for the medical services provided. A practitioner need not obtain informed consent in an emergency situation or in other situations recognized by Washington law. [6]

### Coordination of care

When medically appropriate, a practitioner who uses telemedicine should make referrals to the patient for in-person services that can be delivered in coordination with the telemedicine services. The practitioner should provide a copy of the medical record to other treating practitioners and to the patient upon request.

### Follow-up care

A practitioner who uses telemedicine should have access to, or adequate knowledge of, the nature and availability of local medical resources, including emergency services, to provide appropriate follow-up care to the patient following a telemedicine encounter.

### Medical records

A practitioner who uses telemedicine should maintain complete, accurate, and timely medical records for the patient when appropriate, including all patient-related electronic communications and instructions obtained or produced in connection with the patient visit. The records must be made available to the patient upon request.

### Privacy and security

A practitioner who uses telemedicine should ensure that all telemedicine encounters comply with the privacy and security measures in the Washington Uniform Health Care Information Act, chapter 70.02 RCW, and of the federal health insurance portability and accountability act[7] to ensure that all patient communications and records are secure and remain confidential.

### Mobile medical technology

The federal food and drug administration (FDA) regulates the safety and efficacy of medical devices, including mobile medical applications that meet the definition of "device" under the FDA Act, particularly apps that pose a higher risk if they do not work as intended.

A practitioner who uses a mobile medical technology application that meets the definition of a device under the federal food and drug act, or relies upon such technology, should ensure the application has received approval by the federal food and drug administration or is in compliance with applicable federal law.[8]

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[6] Some examples of exceptions to the requirement to provide informed consent are the emergency exception, RCW 7.70.050(4), RCW 18.71.220; medical holds for minors, RCW 26.44.056; and the therapeutic privilege recognized in *Canterbury v. Spence,* 464 F.2d 772 (D.C. Cir. 1972, *cert. denied,* 409 U.S. 1064 (1972); *Holt v. Nelson,* 11 Wn. App. 230, 523 P.2d 211 (1974), *rev. denied,* 84 Wn. 2d 1008, 523 P.2d 211 (1974).

[7] Also known as the HIPAA Privacy Rule, 45 CFR Part 160, subparts A and E or Part 164.

[8] See https://www.fda.gov/medical-devices/digital-health-center-excellence/device-software-functions-including-mobile-medical-applications

Those applications used by a physician or patient that do not have the data to support their claims may be investigated by the consumer protection division of the Federal Trade Commission (FTC). If the Commission receives complaints about such apps or devices that are deemed outside its jurisdiction, the Commission will advise the complainant to contact the FDA or the FTC as appropriate.

### Artificial intelligence

A practitioner who uses artificial intelligence (AI) tools as part of telemedicine to diagnose or treat a patient in Washington should:

(a) Understand that use of an AI tool and acceptance of suggested diagnosis or related treatment plan is at the discretion of the treating practitioner;

(b) Understand the limitations of using an AI tool, including the potential for bias against populations that are not adequately represented in testing the tool.

A practitioner who uses AI should complete a self-directed CME (category II-V) on bias and underrepresented populations in health care technology applications such as AI.

# Policy

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| | | |
|---|---|---|
| Title: | Clinical Experience Assessment | POL202x-0x |
| References: | | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@wmc.wa.gov |
| Supersedes: | | |
| Effective Date: | | |
| Approved By: | ,Chair | |

## Introduction

In 2020, the Washington State Legislature chose to extend the responsibilities of the International Medical Graduate (IMG) Assistance Work Group with the passage of Senate Bill 6551; thus, creating the IMG Implementation Workgroup (Workgroup). The bill also required that the Washington Medical Commission (Commission) "adopt a clinical assessment to determine the readiness of international medical graduates to apply and serve in residency programs and adopt a grant award process for distributing funds" pursuant to appropriation by the legislature and donations received from public and private entities. After meeting monthly throughout 2022, the Workgroup voted to propose the following Clinical Experience Assessment (CEA) form, Attachment A, which meets the requirement set forth by the legislature.

## Policy

*Purpose of the CEA Form.* The CEA is intended for physician assessors working with IMGs to prepare them for residency and to determine their overall readiness for residency training. The CEA is not an element of application for residency nor is it a qualification for residency.

*Assessment of Residency Preparedness.* The CEA is to be used to assess what level of "entrustment" seems appropriate for the IMG to enter a residency and to aid the IMG in successfully gaining a residency position.

*Frequency of Assessment.* The CEA is to be used as a quarterly assessment tool throughout the program until a passing score on all competencies has been attained, signifying residency readiness.

*Monitoring of the CEA Form's Effectiveness.* As funding and staffing capabilities permit, the Workgroup should develop a monitoring system to track effectiveness and limitations involving the use of the CEA. Once developed, the Workgroup is to begin tracking progress and challenges of IMGs who utilized the CEA form, identify where additional education or targeted trainings may be needed, and adjust to optimize the effectiveness of IMG pre-residency training, and of the CEA form itself.

Attachment A

# Clinical Experience Assessment

Name: Date:

| Ranking Guidelines | | |
|---|---|---|
| 1 | "I did it." | The licensee required complete guidance or was unprepared or not competent; I had to do most of the work myself. |
| 2 | "I talked them through it." | The licensee was able to perform some tasks competently but required repeated directions. |
| 3 | "I directed them from time to time." | The licensee demonstrated some independence and competence and only required intermittent prompting. |
| 4 | "I was available just in case." | The licensee functioned fairly independently and competently and only needed assistance with nuances or complex situations. |
| 5 | "Not observed." | The licensee was not seen or observed completing this task. |

| 1. Gather a History and Perform a Physical Examination | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Obtain a complete and accurate history in an organized fashion. |
| | | | | | Demonstrate patient-centered interview skills. |
| | | | | | Demonstrate clinical reasoning in gathering focused information relevant to a patient's care. |
| | | | | | Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit. |
| 2. Prioritize a Differential Diagnosis Following a Clinical Encounter | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis. |

| 1 | 2 | 3 | 4 | 5 | Task |
|---|---|---|---|---|---|
| | | | | | Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity. |
| | | | | | Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans. |
| 3. Recommend and Interpret Common Diagnostic and Screening Tests | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders. |
| | | | | | Interpret results of basic studies and understand the implication and urgency of the results. |
| 4. Enter and Discuss Orders and Prescriptions | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Compose orders efficiently and effectively verbally, on paper, and electronically. |
| | | | | | Demonstrate an understanding of the patient's condition that underpins the provided orders. |
| | | | | | Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts. |
| | | | | | Discuss planned orders and prescriptions with team, patients, and families. |
| 5. Document a Clinical Encounter in the Patient Record | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Prioritize and synthesize information into a cogent narrative for a variety of clinical encounters (admission, progress, pre- and post-op, and procedure notes; informed consent; discharge summary). |
| | | | | | Follow documentation requirements to meet regulations and professional expectations. |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Document a problem list, differential diagnosis, and plan supported through clinical reasoning that reflects patient's preferences. |
| 6. Provide an Oral Presentation of a Clinical Encounter | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Present personally gathered and verified information, acknowledging areas of uncertainty |
| | | | | | Provide an accurate, concise, well-organized oral presentation. |
| | | | | | Adjust the oral presentation to meet the needs of the receiver. |
| | | | | | Demonstrate respect for patient's privacy and autonomy. |
| 7. Form Clinical Questions and Retrieve Evidence to Advance Patient Care (*only level 3 required) | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK). |
| | | | | | Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE). |
| | | | | | *Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE). |
| | | | | | *Apply findings to individuals and/or patient panels; communicate findings to the patient and team, reflecting on process and outcomes (ADVISE). |
| 8. Give or Receive a Patient Handover to Transition Care Responsibility | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Document and update an electronic handover tool and apply this to deliver a structured verbal handover, using communication strategies known to minimize threats to transition of care |
| | | | | | Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning. |
| | | | | | Demonstrate respect for patient's privacy and confidentiality. |

| 9. Collaborate as a Member of an Interprofessional Team | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Identify team members' roles and responsibilities and seek help from other members of the team to optimize health care delivery. |
| | | | | | Include team members, listen attentively, and adjust communication content and style to align with team-member needs. |
| | | | | | Establish and maintain a climate of mutual respect, dignity, integrity, and trust; prioritize team needs over personal needs to optimize delivery of care; and help team members in need. |
| 10. Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management (*only level 3 required) | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient's decompensation. |
| | | | | | Recognize severity of a patient's illness and indications for escalating care. |
| | | | | | *Initiate and participate in a code response and apply basic and advanced life support. |
| | | | | | Upon recognition of a patient's deterioration, communicates situation to attending physician. |
| 11. Obtain Informed Consent for Tests and/or Procedures | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Describe the key elements of informed consent: indications, contraindications, risks, benefits, alternatives, and potential complications of the intervention. |
| | | | | | Communicate with the patient and family to ensure that they understand the intervention including pre/post procedure activities. |

| 12. Perform General Procedures of a Physician (*only level 3 required) | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | *Demonstrate technical skills required for the procedure. |
| | | | | | Understand and explain the anatomy, physiology, indications, contraindications, risks, benefits, alternatives, and potential complications of the procedure. |
| | | | | | Completes expected procedures and keeps log book signed by mentor |
| 13. Identify System Failures and Contribute to a Culture of Safety and Improvement (*only level 3 required) | | | | | |
| 1 | 2 | 3 | 4 | 5 | Task |
| | | | | | Identify and report actual and potential ("near miss") errors in care using system reporting structure (event reporting systems, chain of command policies). |
| | | | | | Participate in system improvement activities in the context of learning experiences (rapid- cycle change using plan–do–study– act cycles, root cause analyses, morbidity and mortality conference, failure modes and effects analyses, improvement projects). |
| | | | | | Engage in daily safety habits (accurate and complete documentation, including allergies and adverse reactions, medicine reconciliation, patient education, universal precautions, hand washing, isolation protocols, falls and other risk assessments, standard prophylaxis, time-outs). |
| | | | | | Admit one's own errors, reflect on one's contribution, and develop an individual improvement plan. |